

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN2801	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  01/27/2010
NAME OF PROVIDER OR SUPPLIER  SOUTHERN TENN MEDICAL CENTER SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 628 HOSPITAL ROAD WINCHESTER, TN 37398		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies  Based on observations, testing and records review on 1/27/10, it was determined the facility was in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board of Licensing Health Care Facilities and Chapter 1200-08-06 Standards for Nursing homes.		N 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE SIGNATURE

STATE FORM

TITLE

(X6) DATE

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X4D021

If continuation sheet 1 of 1

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN2601</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>03 - EMERALD/HODGSON</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/27/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTHERN TENN MEDICAL CENTER SNF</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>629 HOSPITAL ROAD WINCHESTER, TN 37398</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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STATE FORM

6899

X4D021

If continuation sheet 1 of 1